		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0022350

Facility Name: WESLEY VILLAGE UMC HEALTH CARE CENTER

Address: 1200 EAST GRANT ST. (Number) MACOMB (City) 61455 (Zip Code)

County: MCDONOUGH

Telephone Number: 309-833-2123 **Fax #** 309-837-7500

IDPA ID Number: 370996594001

Date of Initial License for Current Owners: 4/14/1980

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: SHELLY WARD **Telephone Number:** 309-833-2123
DIRECTOR OF FINANCE

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 2/1/2000 to 1/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) 9/28/01 (Date)
(Type or Print Name) RAYMOND F. POE
(Title) ADMINISTRATOR

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number WESLEY VILLAGE UMC HEALTH CARE CENTER # 0022350 Report Period Beginning: 2/1/2000 Ending: 1/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	80	Intermediate (ICF)	80	29,280	3
4		Intermediate/DD			4
5	4	Sheltered Care (SC)	4	1,464	5
6		ICF/DD 16 or Less			6
7	84	TOTALS	84	30,744	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	14,540	10,276		24,816	10
11	ICF/DD					11
12	SC		557		557	12
13	DD 16 OR LESS					13
14	TOTALS	14,540	10,833		25,373	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.53%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 4/14/1980

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: TAX EXEMPT Fiscal Year:

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number WESLEY VILLAGE UMC HEALTH CARE # 0022350 Report Period Beginning: 2/1/2000 Ending: 1/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	174,998	22,066	4,408	201,472		201,472	(390)	201,082			1
2	Food Purchase		155,668		155,668		155,668		155,668			2
3	Housekeeping	79,538	15,734	556	95,828	44,508	140,336		140,336			3
4	Laundry	18,465		41,577	60,042		60,042		60,042			4
5	Heat and Other Utilities			73,454	73,454		73,454		73,454			5
6	Maintenance	25,704	13,587	5,987	45,278		45,278		45,278			6
7	Other (specify):*											7
8	**TOTAL General Services**	298,705	207,055	125,982	631,742	44,508	676,250	(390)	675,860			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,057,329	103,271	386,010	1,546,610	(75,076)	1,471,534		1,471,534			10
10a	Therapy											10a
11	Activities	55,269	6,144	10,458	71,871		71,871	(3,928)	67,943			11
12	Social Services					29,275	29,275		29,275			12
13	Nurse Aide Training			1,356	1,356		1,356		1,356			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,112,598	109,415	397,824	1,619,837	(45,801)	1,574,036	(3,928)	1,570,108			16
	C. General Administration											
17	Administrative	101,190			101,190		101,190		101,190			17
18	Directors Fees											18
19	Professional Services			10,709	10,709		10,709		10,709			19
20	Dues, Fees, Subscriptions & Promotions			13,017	13,017	(3,571)	9,446	(3,731)	5,715			20
21	Clerical & General Office Expenses	40,346	6,152	9,335	55,833		55,833		55,833			21
22	Employee Benefits & Payroll Taxes			241,271	241,271		241,271		241,271			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,068	9,068		9,068	(243)	8,825			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			10,301	10,301		10,301		10,301			26
27	Other (specify):*											27
28	**TOTAL General Administration**	141,536	6,152	293,701	441,389	(3,571)	437,818	(3,974)	433,844			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,552,839	322,622	817,507	2,692,968	(4,864)	2,688,104	(8,292)	2,679,812			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number WESLEY VILLAGE UMC HEALTH CARE CENTER #0022350 Report Period Beginning: 2/1/2000 Ending: 1/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			119,045	119,045		119,045	(11,526)	107,519			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			78,855	78,855	4,864	83,719		83,719			32
33	Real Estate Taxes			31,845	31,845		31,845		31,845			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			229,745	229,745	4,864	234,609	(11,526)	223,083			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			43,920	43,920		43,920		43,920			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			43,920	43,920		43,920		43,920			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,552,839	322,622	1,091,172	2,966,633		2,966,633	(19,818)	2,946,815			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WESLEY VILLAGE UMC HEALTH CARE CENTER # 0022350 Report Period Beginning: 2/1/2000 Ending: 1/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	3,928	LN 11		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	11,526	LN 30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	390	LN 2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	243	LN 24		16
17	Non-Care Related Fees				17
18	Fines and Penalties	3,055	LN 20		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	676	LN 20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 19,818		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense	7,222	X-F	33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 7,222		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 27,040		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Page 5A

WESLEY VILLAGE UMC HEALTH CARE CENTER

ID# 0022350

Report Period Beginning: 2/1/2000

Ending: 1/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number WESLEY VILLAGE UMC HEALTH CARE CENTER **#** 0022350 **Report Period Beginning:** 2/1/2000 **Ending:** 1/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number WESLEY VILLAGE UMC HEALTH CARE CENTER **#** 0022350 **Report Period Beginning:** 2/1/2000 **Ending:** 1/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	0	0	0	0	0	0	0	0	0	0	0	45

Facility Name & ID Number WESLEY VILLAGE UMC HEALTH CARE CENTER # 0022350 Report Period Beginning: 2/1/2000 Ending: 1/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		NOT APPLICABLE				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$	NOT APPLICABLE		$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WESLEY VILLAGE UMC HEALTH CARI # 0022350 Report Period Beginning: 2/1/2000 Ending: 1/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	NOT APPLICABLE								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WESLEY VILLAGE UMC HEALTH CARE CENTER # 0022350 Report Period Beginning: 2/1/2000 Ending: /31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization NOT APPLICABLE
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		NOT APPLICABLE				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WESLEY VILLAGE UMC HEALTH CARE # 0022350 Report Period Beginning: 2/1/2000 Ending: 1/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	SUBORDINATED DEBENTURES		X	FACILITY CONSTRUCTION		VARIOUS	$ 323,005	$ 193,320	VARIOUS		$ 14,421	1
2												2
3	AMERICAN NATIONAL BANK		X	REFINANCE & NEW	ANNUAL	8/13/1996	2,602,185	2,152,077	8/1/2017		69,298	3
4				CONSTRUCTION	PAYMENTS							4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 2,925,190	$ 2,345,397			$ 83,719	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,925,190	$ 2,345,397			$ 83,719	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number WESLEY VILLAGE UMC HEALTH CARE CENTER # 0022350 Report Period Beginning: 2/1/2000 Ending: 1/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	31,845	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	31,845	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	27,477	8
	1997	29,637	9
	1998	32,462	10
	1999	32,462	11
	2000	31,845	12

2000 REAL ESTATE TAX ACCRUED IN FISCAL YEAR 2001 PAID IN FULL 8/10 & 9/6/01

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WESLEY VILLAGE UMC HEALTH CARE CENTER COUNTY MCDONOUGH

FACILITY IDPH LICENSE NUMBER 0022350

CONTACT PERSON REGARDING THIS REPORT SHELLY WARD

TELEPHONE 309-833-2123 FAX #: 309-837-7500

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-301-283-00	WESLY VILLAGE BUILDING & LA	$ 52,943.52	$ 31,845.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 52,943.52	$ 31,845.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number WESLEY VILLAGE UMC HEALTH CARE CENTER # 0022350 Report Period Beginning: 2/1/2000 Ending: 1/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,893 B. General Construction Type: Exterior BRICK Frame PRESTRESSED CON(Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

WESLEY VILLAGE, U.M.C. - RETIREMENT CENTER - 75 UNITS

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 144,434
2. Number of Years Over Which it is Being Amortized: 20
3. Current Period Amortization: 7,222
4. Dates Incurred: 2/1/1997-1/31/1998

Nature of Costs: BOND ISSUANCE EXPENSES - 1998 NEW CONSTRUCTION - ALZHEIMER'S UNIT
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	235,224	1975	$ 48,600	1
2					2
3	TOTALS	235,224		$ 48,600	3

Facility Name & ID Number WESLEY VILLAGE UMC HEALTH CARE CENTER # 0022350 Report Period Beginning: 2/1/2000 Ending: 1/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	58		1980	1980	$ 1,304,649	$ 25,968	50	$ 25,968	$	$ 536,817	4
5	26		1998	1997	1,934,404	50,214	50	38,688	(11,526)	116,064	5
6											6
7											7
8											8
	Improvement Type**										
9	LAND IMPROVEMENTS										9
10	Paved Parking Lost			1981	28,080		15			28,080	10
11	Landscaping			1981	2,943		10			2,943	11
12	Landscaping			1984	227		10			227	12
13	Blacktop Driveway			1985	559		10			559	13
14	Landscaping, Install Cement Patio			1982	488		20			681	14
15	Landscaping			1983	681		20			681	15
16	Blacktop Driveway			1986	2,668	178	15	178		2,536	16
17	Blacktop Driveway			1987	15,464	1,032	15	1,032		13,785	17
18	Improve Drainage			1987	1,036	69	15	69		897	18
19	Landscaping Costs			1988	599		10			599	19
20	Improve Drainage from Roof Area			1989	946	66	15	66		755	20
21	Blacktop Sealing			1990	1,394	93	15	93		973	21
22	Blacktop Sealing			1991	1,054	71	15	71		665	22
23	Blacktop Sealing			1994	1,307	87	15	87		566	23
24	Turf & Garden Mix 38%			1997	322	13	10	13		52	24
25	1 Concrete Curbing 38%			1997	418	10	20	10		40	25
26	1 Concrete Curbing 38%			1997	562	7	20	7		28	26
27	Walking Path 50%			2000	17,911	896	20	896		896	27
28	Alzheimers's Garden Enhancement			2000	4,468	223	20	223		223	28
29											29
30	BUILDING IMPROVEMENTS										30
31	Screens & Doors			1981	4,500		10			4,500	31
32	Constructed Carports			1981	2,000	40	50	40		760	32
33	Wallpaper			1981	2,264	108	20	108		2,052	33
34	Entrance Signs			1981	5,920	208	30	208		3,989	34
35	Signs			1981	58		12			58	35
36	Intangibles			1981	5,742	287	20	287		5,453	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number WESLEY VILLAGE UMC HEALTH CARE CENTER # 0022350 Report Period Beginning: 2/1/2000 Ending: 1/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Overhang Roof Drains	1982	$ 342	$ 17	20	$ 17	$	$ 306	37
38	Remodel Bathroom	1982	371	8	50	8		144	38
39	Exhaust Fan & Lights	1982	426	25	20	25		426	39
40	Carpet	1983	169		5			169	40
41	Install Satellite System	1983	4,122		15			4,122	41
42	Remodeling	1983	389	8	50	8		135	42
43	Wheelchair Ramp	1984	407		10			407	43
44	Remodel Showers	1984	501	17	30	17		256	44
45	Install Decoder	1985	450	30	15	30		450	45
46	Redecorate Resident Rooms	1985	10,126	348	15	348		10,126	46
47	Install Tornado Siren	1986	3,056	204	15	204		2,950	47
48	Carpet	1987	538		5			538	48
49	Install TV Filter	1987	68	5	15	5		65	49
50	Redecorate Resident Rooms	1987	7,274	490	15	490		6,696	50
51	Remodeling Hallway	1988	68	5	15	5		63	51
52	Roof Repairs	1989	3,704	247	15	247		2,717	52
53	Emergency Light	1989	35		10			35	53
54	Redecorating	1989	13,802	920	15	920		9,493	54
55	Nurse Call System	1990	4,919	315	15	315		2,663	55
56	Elevator jack	1990	3,780	240	15	240		2,400	56
57	Solid Core Door	1990	735	69	10	69		735	57
58	Water System Repair	1991	1,410	141	10	141		1,269	58
59	Water Heater Repairs	1991	1,323	132	10	132		1,188	59
60	Replace Window Panes	1991	9,051	476	20	476		4,509	60
61	Install A/C Food Service	1992	866	43	20	43		387	61
62	Roof Repairs	1992	8,685	579	15	579		5,211	62
63	Redesign Water System	1992	2,385	95	20	95		760	63
64	Remodeling	1992	9,845	656	15	656		5,248	64
65	Carpeting	1993	851	57	15	57		427	65
66	Remodeling	1993	1,540	154	10	154		1,155	66
67	New Entryway	1994	7,888	484	20	484		3,049	67
68	Remodeling	1994	3,216	322	10	322		1,932	68
69	Painting to Entry way & Carpet	1995	2,456	246	10	246		1,424	69
70	TOTAL (lines 4 thru 69)		$ 3,445,462	$ 85,903		$ 74,377	$ (11,526)	$ 796,334	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WESLEY VILLAGE UMC HEALTH CARE CENTER # 0022350 Report Period Beginning: 2/1/2000 Ending: 1/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,445,462	$ 85,903		$ 74,377	$ (11,526)	$ 796,334	1
2	Dining Room Floor	1996	116	6	20	6		25	2
3	Roof Repairs - West End	1996	385	26	15	26		119	3
4	12 Air Conditioning Units	1996	3,698	247	15	247		803	4
5	Shingle East Entrance	1997	398	26	15	26		85	5
6	Border - Residents Rooms	1997	484	25	10	25		79	6
7	Carpet Installation Hallway	1997	265	13	20	13		41	7
8	Vinyl Floor Covering - Corridor	1997	1,507	75	20	75		225	8
9	Remote Annunicator Panel	1997	705	34	20	34		120	9
10	6 Heating / Air Conditioning Units	1997	1,602	80	20	80		247	10
11	3 Windows	1997	116	6	20	6		19	11
12	12 Window Screens	1997	126	6	20	6		20	12
13	Carpet	1997	432	36	20	36		108	13
14	Drainage from SE Corner of Building	1997	378	24	15	24		85	14
15	Additional Wiring to Pass Inspection	1998	4,748	237	20	237		613	15
16	Window Treatments	1998	10,940	547	20	547		1,459	16
17	Mixing Valve	1998	2,695	180	15	180		390	17
18	Tuckpointing - Building Exterior	1998	4,511	180	25	180		390	18
19	Flooring	1998	665	44	15	44		129	19
20	New Fire Alarms in Health Care Center	1998	10,468	523	20	523		1,134	20
21	Additional Strobes Due to Inspection	1998	1,381	69	20	69		190	21
22	Roof Repairs - Kitchen & SE Section	1998	9,060	362	25	362		815	22
23	Alzheimer Unit Lounge Flooring	1999	1,074	54	15	54		108	23
24	Health Care Lighting Upgrade	1999	2,019	135	10	135		270	24
25	Fire Alarm -Upgrade	1999	2,814	164	10	164		328	25
26	Heating/Cooling Laundry Room & Kitchen Corridor	2000	9,000	450	20	450		450	26
27	Sewer Line	2000	8,868	355	25	355		355	27
28	Smoking Patio	2000	2,590	130	20	130		130	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,526,507	$ 89,937		$ 78,411	$ (11,526)	$ 805,071	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WESLEY VILLAGE UMC HEALTH CARE CENT # 0022350 Report Period Beginning: 2/1/2000 Ending: 1/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 490,562	$ 26,538	$ 26,538	$		$ 31,700	71
72	Current Year Purchases	22,054	2,570	2,570			2,570	72
73	Fully Depreciated Assets	23,725					23,725	73
74								74
75	TOTALS	$ 536,341	$ 29,108	$ 29,108	$		$ 57,995	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,111,448	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 119,045	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 107,519	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (11,526)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 863,066	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	NONE	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	NONE	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NOT APPLICABLE
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ ____ Description: ____
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WESLEY VILLAGE UMC HEALTH CARE CENTER # 0022350 Report Period Beginning: 2/1/2000 Ending: 1/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE 80

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$ 1,264	$	$ 1,264
2	Books and Supplies		91		91
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 1,355	$	$ 1,355
10	SUM OF line 9, col. 1 and 2 (e)	$ 1,355			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	NOT APPLICABLE	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number WESLEY VILLAGE UMC HEALTH CARE CENTER **#** 0022350 **Report Period Beginning:** 2/1/2000 **Ending:** 1/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 1/31/2001 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 182,317	$ 303,862	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	259,891	282,002	3
4	Supply Inventory (priced at)	26,000	43,123	4
5	Short-Term Investments	1,110,322	1,390,665	5
6	Prepaid Insurance	6,600	15,407	6
7	Other Prepaid Expenses	1,295	1,295	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,586,425	$ 2,036,354	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	213,425	315,038	12
13	Land	48,600	360,000	13
14	Buildings, at Historical Cost	3,526,507	7,385,546	14
15	Leasehold Improvements, at Historical Cost		268,881	15
16	Equipment, at Historical Cost	536,341	998,854	16
17	Accumulated Depreciation (book methods)	(1,130,378)	(3,157,703)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	144,304		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(21,666)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,317,133	$ 6,170,616	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,903,558	$ 8,206,970	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 66,213	$ 110,355	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	93,320	385,000	29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses		272,298	36
37	Life Member Fees,Apt Deposit, Annuity Payable		602,557	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 159,533	$ 1,370,210	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	100,000	516,000	39
40	Mortgage Payable			40
41	Bonds Payable	2,152,077	2,875,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,252,077	$ 3,391,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,411,610	$ 4,761,210	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,491,948	$ 3,445,760	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,903,558	$ 8,206,970	48

***(See instructions.)**

Facility Name & ID Number WESLEY VILLAGE UMC HEALTH CARE CENTER # 0022350 Report Period Beginning: 2/1/2000 Ending: 1/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,038,931	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,038,931	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(546,983)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (546,983)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,491,948	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number WESLEY VILLAGE UMC HEALTH CARE CEN # 0022350 Report Period Beginning: 2/1/2000 Ending: 1/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,323,058	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,323,058	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions	96,592	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 96,592	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,419,650	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	631,742	31
32	Health Care	1,619,837	32
33	General Administration	441,389	33
	B. Capital Expense		
34	Ownership	229,745	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	43,920	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,966,633	40
41	**Income before Income Taxes (line 30 minus line 40)****	(546,983)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (546,983)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** N/A **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WESLEY VILLAGE UMC HEALTH CARE CENTER # 0022350 Report Period Beginning: 2/1/2000 Ending: 1/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,775	2,080	$ 38,885	$ 18.69	1
2	Assistant Director of Nursing	2,921	3,041	63,439	20.86	2
3	Registered Nurses	7,278	7,599	125,549	16.52	3
4	Licensed Practical Nurses	9,399	10,323	136,913	13.26	4
5	Nurse Aides & Orderlies	53,673	56,782	548,957	9.67	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,000	2,100	23,100	11.00	9
10	Activity Assistants	2,733	3,100	32,169	10.38	10
11	Social Service Workers	2,117	2,292	29,275	12.77	11
12	Dietician					12
13	Food Service Supervisor	1,470	1,545	18,548	12.01	13
14	Head Cook	1,470	1,545	12,360	8.00	14
15	Cook Helpers/Assistants	14,555	15,503	118,740	7.66	15
16	Dishwashers	3,500	3,900	25,350	6.50	16
17	Maintenance Workers	1,983	2,176	25,704	11.81	17
18	Housekeepers	9,262	9,943	78,600	7.91	18
19	Laundry	6,406	6,566	44,508	6.78	19
20	Administrator	1,485	1,664	60,800	36.54	20
21	Assistant Administrator	1,856	2,080	40,390	19.42	21
22	Other Administrative	1,500	1,617	19,404	12.00	22
23	Office Manager					23
24	Clerical	3,161	3,452	40,346	11.69	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	173	2,117	19,691	9.30	31
32	Other Health Care(specify)					32
33	Other(specify) UNIT COORD	2,694	2,838	50,111	17.66	33
34	TOTAL (lines 1 - 33)	131,411	142,263	$ 1,552,839 *	$ 10.92	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	150	$ 3,854	LN 1,COL3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	24	1,800	LN 10,COL3	39
40	Physical Therapy Consultant	43	1,925	LN 10,COL3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	18	910	LN 11, COL3	44
45	Social Service Consultant	18	910	LN 10,COL3	45
46	Other(specify) ALZHEIMER'S	190	3,790	LN 10,COL3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	443	$ 13,189		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	972	$ 29,041	LN 10,COL3	50
51	Licensed Practical Nurses	6,721	173,709	LN 10,COL3	51
52	Nurse Aides	9,084	150,780	LN 10,COL3	52
53	TOTAL (lines 50 - 52)	16,777	$ 353,530		53

Facility Name & ID Number WESLEY VILLAGE UMC HEALTH CARE CENT # 0022350 Report Period Beginning: 2/1/2000 Ending: 1/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
RAYMOND F. POE	ADMINSTRATOR	0	$ 60,800
SHELLY L. WARD	FINANCE DIRECTOR	0	40,390
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 101,190

B. Administrative - Other

Description	Amount
NOT APPLICABLE	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
CLIFTON-GUNDERSON, LLC	AUDIT/ACCOUNTING	$ 8,400
MARCH & MCMILLAN	LEGAL	2,309
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 10,709

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 117,570
Unemployment Compensation Insurance	52,365
FICA Taxes	71,336
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 241,271

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
NOT APPLICABLE		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,065
Health Care Worker Background Check	228
(Indicate # of checks performed 19)	
DUES-SEE ATTACHED SCHEDULE	4,422
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,715

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	8,825
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,825

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WESLEY VILLAGE UMC HEALTH CARE CENTER # 0022350 Report Period Beginning: 2/1/2000 Ending: 1/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	NOT APPLICABLE		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number WESLEY VILLAGE UMC HEALTH CARE CENTER # 0022350 Report Period Beginning: 2/1/2000 Ending: 1/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **LIFE SERVICES NETWORK**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **12,603** Line **10, COL 3**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **43,920**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? _____ Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **CLIFTON-GUNDERSON, LLC** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **YES** If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

WESLEY VILLAGE, UMC
REAL ESTATE TAX
COST ALLOCATION

2000 TAX BILL

PROPERTY #	11-3010283-00			$ 52,943.52
TOTAL SQ FOOTAGE		62998		
NURING FACILITY SQ FT		37893	60.15%	**$ 31,845.28**